Akrotiri Health Centre

DPHC Overseas, RAF Akrotiri, Cyprus, BFPO 57

Defence Medical Services inspection report

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the practice and patient feedback about the service.

Overall rating for this service	**Good**	
Are services safe?	**Good**	
Are services effective	**Good**	
Are service caring?	**Good**	
Are services responsive to people's needs?	**Requires improvement**	
Are services well-led?	**Good**	

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Summary

About this inspection

We carried out this announced comprehensive inspection on 11 October 2023.

As a result of this inspection the practice is rated as good overall in accordance with the Care Quality Commission's (CQC) inspection framework.

Are services safe? – good

Are services effective? – good

Are services caring? – good

Are services responsive to people's needs? – requires improvement

Are services well-led? – good

CQC does not have the same statutory powers with regard to improvement action for the Defence Medical Services (DMS) under the Health and Social Care Act 2008, which also means that the DMS is not subject to CQC's enforcement powers. However, as the military healthcare regulator, the Defence Medical Services Regulator (DMSR) has regulatory and enforcement powers over the DMS. DMSR is committed to improving patient and staff safety and will ensure implementation of the CQC's observations and recommendations.

This inspection is one of a programme of inspections the CQC will complete at the invitation of the DMSR in its role as the military healthcare regulator for the DMS.

At this inspection we found:

- Feedback showed patients were treated with compassion, dignity and respect and were involved in care and decisions about their treatment.
- Patients who contributed to the inspection expressed a dissatisfaction with secondary care, mainly in relation to untimely and fragmented communication between practice doctors and secondary care consultants.
- The new leadership team had a clear vision about changes that needed to be made to ensure the safety, effectiveness and efficiency of the service was maximised.
- There was an inclusive culture at the practice with all departments, including the Primary Care Rehabilitation Facility (PCRF), actively engaged in governance activities.
- There was an open and transparent approach to safety. A well-developed system was in place for managing significant events. All significant events and incidents were subject to a thorough root cause analysis involving key staff.
- The practice worked collaboratively with internal stakeholders, including the welfare team, SSAFA (Armed Forces charity) and the Department of Community Mental

Health. Staff suggested that it would be beneficial if the practice was included in the design and review of secondary care contracts.

- Although patients received their medicines in a safe way, we identified minor issues with the governance of medicines.
- Healthcare governance processes were routinely used to monitor service performance. Work was in progress to review the processes to ensure all information was captured in a clear and systematic way.
- Quality improvement activity was embedded in practice and was used to drive improvements in patient care. This could be progressed further by showcasing all initiatives as quality improvement projects.

We identified the following notable practice, which had a positive impact on patient experience:

- The PCRF team identified that local pathways for the management of acute musculoskeletal injuries lacked clarity. In response, the team developed local guidance that took account of both best practice guidelines and the differences in management due to the nature of local hospital support.
- In response to understanding the increasing use of eConsult, an audit was carried out in May 2023. Key trends were identified from the audit resulted in the development of a quarterly electronic interactive user-friendly patient newsletter. It covered a wide range of topics to support patients with understanding what the health centre provided and when and how to seek healthcare intervention. A wide range of information about health was captured, such as the different types of appointments required depending on the symptoms the patient was experiencing. Some of the information related to lifestyle, mental health, flu vaccination eligibility, carrying out skin checks and services available to carers. Various links and quick response codes were embedded including a link to ‘Healthier together’, a nationally recognised website providing advice for parents, young people and pregnant woman. This newsletter was a positive example of an initiative taken to enhance the health literacy of the patient population.
- A ‘traffic light’ process, including a flow chart and guidance, was used by the reception team to ensure patients making contact with the practice for the first time were directed to the most appropriate clinician/team. This process supported with streamlining the service and maximised patients being seen in a timely manner by the correct clinician. Furthermore, it aimed to prevent inappropriate clinic loading by prioritising individual need.
- The practice identified that health promotion assets across British Forces Cyprus were lacking. With additional funding secured, the practice started a 'health promotion library'. Resources purchased include smoking/vape cessation displays, sugar displays, drink displays, skin cancer discs, breast and testicle displays. These have been used for patient education, at health fairs and sometimes for other population groups such as school children. The practice loans these resources out across island for wider population benefit.
- The MASSH nurse was actively involved with sexual health promotion, including to the school nurse and the setting up of a youth drop in clinic. They briefed every regiment

arriving on the island, talking about the risks associated with sexual health and how to access screening and support.

- The practice identified that sometimes the scheduled ASER meeting was too far in the future to discuss a significant event which may have just happened. To capture details in a timely way and enable prompt lessons learnt, the practice introduced the 'SWARM' template. This supported with quickly identifying whether immediate action or change was needed following the significant event/incident or whether it could wait until the ASER meeting and a full root cause analysis.

The Chief Inspector recommends to Defence Primary Healthcare (DPHC) and British Forces Cyprus (BFC):

- Without delay, BFC should undertake a review of secondary health care (SHC) provision. The review should actively engage patients who have experience of SHC provision, practice clinicians and the practice leadership team. In addition, an analysis of complaints and significant events should be undertaken to identify trends in relation to SHC. Feedback and the development of an improvement plan should involve a wide-range of stakeholders, including patients and practice staff.
- Expediate the process for securing Disclosure and Barring Service (DBS) checks so that staff receive DBS checks in a timely way.
- Ensure the practice submission for an uplift of 4 medics is addressed in a timely manner.
- Review DMICP access with a view to the provision of DMICP Fixed to improve patient-related communication with other Defence medical centres on the island and with Defence Medical Services in the UK.

The Chief Inspector recommends to the health centre:

- Based on an analysis of complaints and feedback about SHC services, actively engage with patients so they have a clearer understanding of how SHC is provided, including timelines and communication pathways. This could be achieved through a patient participation group setting.
- Review and extent the local working policy (LWP) for telephone triage to included face-to-face triage and the circumstances in which a child is referred to the duty doctor. The LWP should outline the arrangements for clinical advice and supervision available to nurses and medics involved with the triage, assessment and treatment of children.
- Replace the older red hospital-style medical emergency trolley with a more modern version as there is a potential risk the emergency medicines compartment cannot be accessed promptly in the event of a medical emergency.
- Review governance systems to maximise the safety of how over-labelled medicines are managed and accounted for to ensure adherence with organisational policy. In addition, ensure staff have access to the LWP for the supply of over-labelled medicines out-of-hours.

- The musculoskeletal health questionnaire (referred to as MSK-HQ) and Rehab Menu Templates should be routinely used by the PCRF team as this is a mandatory requirement.
- Consider ways to engage with patients so they gain a clearer understanding of the complaint process, in particular the complaints pathway for SHC services.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Healthcare

Our inspection team

The inspection team included 2 CQC inspectors and a range of specialist advisors - a primary care doctor, practice nurse, pharmacist and physiotherapist. A member of the Defence Medical Services Regulator supported the inspection.

Background to Akrotiri Health Centre

Located in the Western Sovereign Base Area of Cyprus, Akrotiri Health Centre provides a routine primary care service to a current patient population of 3,000. The population comprises 1,332 service personnel and 1,668 civilians, including families of service personnel. There were 798 registered patients under the age of 18. The health centre also provides an occupational health service for military personnel. Additionally, it provides airfield crash cover 24 hours a day 7 days a week with a dedicated crash ambulance staffed by a duty crash medic.

The Primary Care Rehabilitation Facility (PCRF) is co-located with the health centre and provides a physiotherapy and rehabilitation service for service personnel and civilians. A dispensary is based in the health centre.

Secondary care is provided primarily by the American Medical Centre in Nicosia. Patients requiring obstetrics care are referred to the Hippocrateon Hospital. Other government hospitals utilised include Limassol General, Nicosia General, Archbishop Makarios Hospital (ABM) and Ammochostos (Paralimni) General Hospital. In addition, patients can be returned to the UK for secondary care.

The health centre is open from 06:45 to 13:45 hours Tuesday, Thursday and Friday, opening 06:45 to 15:45 Monday and Wednesday. Outside of these hours, including weekends and public holidays, cover is provided by a paramedic and medic with a duty doctor on call. This provides the 112 Ambulance response, and the equivalent 111 primary health medical cover.

The staff team

Doctors	**Established for 6** Senior Medical Officer Deputy Senior Medical Officer Military doctors x 2 Civilian Medical Practitioners x 2
Nurses	**Established for 5** Senior Nursing Officer Military nurses x 2 Civilian nurses x 2

Medics	**Established for 22** 15 medics in post
Practice management	**Established for 4** Military Warrant Officer Military practice manager Military deputy practice manager
PCRF	**Established for 4** OC physiotherapist – **post vacant** Band 6 civilian senior physiotherapist Locum Band 7 civilian physiotherapist Military exercise rehabilitation instructor
Dispensary	**Established for 2** Military pharmacy technician Civilian pharmacy technician
Administrators	**Established for 6** Six civilian administrators

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

One of the doctors was the lead for adult and children safeguarding and the Senior Medical Officer (SMO) deputised. Staff had completed safeguarding training at a level appropriate to their role, including physiotherapists who were trained to level 3 as they treated children and young people. The practice worked to the British Forces Cyprus (BFC) standard operating procedure (SOP) for safeguarding children and adults.

Safeguarding information was displayed for staff reference, including a referral process flow chart and links to relevant agencies. Concerns about children were reported to the safeguarding lead in the SSAFA team based in the health centre. In Cyprus, SSAFA provides community services through a contract with Headquarters (HQ) BFC. The SSAFA team included health visitors, a school nurse and midwife. The practice had access to a BFC social worker. It was evident from discussions with staff that a multi-disciplinary team approach was taken in relation to the safeguarding of vulnerable patients.

Vulnerable patients were identified during consultations, DMICP Deployed (patient electronic record for overseas practices) monthly searches and through referrals from other units, such as the welfare team or SSAFA. Our review of clinical records indicated a clinical code was applied to the records of patients deemed vulnerable. A database was maintained of patients under the age of 18.

Vulnerable patients were reviewed at the clinical meetings held each month. Patients discussed were added to a ‘ghost clinic’ on DMICP and an entry made in their health record. In addition, Health and Wellbeing Committee (referred to as HAWC) quarterly meetings were facilitated by the station, at which the practice was represented.

Information highlighting the availability of chaperones was displayed throughout the premises and also outlined in the practice information leaflet. Clinical staff acted as chaperones and had received update training in October 2023. The offer and/or use of a chaperone was recorded in the patients’ records we reviewed. Primary Care Rehabilitation Facility (PCRF) staff also recorded the offer/use of a chaperone particularly for opposite sex patients and patients under the age of 18. One of the physiotherapists advised they did not see patients under the age of 16 without parental supervision.

Although the full range of recruitment records for permanent staff was held centrally, the practice could demonstrate that relevant safety checks were undertaken at the point of recruitment, including formal safety checks to ensure staff were suitable to work with vulnerable adults and children. The majority of staff had an up-to-date current English Disclosure and Barring Service (DBS) check. The DBS checks had expired for 5 staff; all had applied for a new check in sufficient time. The practice indicated the applications had not progressed through the unit human resources system. In the interim, a line manager’s risk assessment had been completed for each of the staff to ensure they could continue to work in the service. Risks assessments were forwarded to the overseas regional

safeguarding lead. A process was in place to monitor the professional registration of clinical staff and all were in-date at the time of the inspection.

An infection prevention and control (IPC) policy was in place. One of nurses was the lead for IPC and had completed the required training for the role. The practice followed the mandated Defence Primary Healthcare (DPHC) monthly rolling IPC audit programme. We reviewed the 3 recent most recent audits and the actions identified had been completed. The exercise rehabilitation instructor (ERI) was undertaking a cleaning audit of the PCRF and monitored the cleaning of these areas. They used the audit report to feed back to the cleaning contractor. The equipment and sharps bins were in-date for the provision of acupuncture.

An environmental cleaning contract was established for the practice and a detailed cleaning schedule was in place and was displayed throughout the practice. A process was established to confirm cleaning had been carried out in accordance with the schedule. The Warrant Officer advised that a formal deep clean of the premises was not included in the cleaning contract. Identified on the Practice Development Plan, this was being addressed as part of the contract renewal process. The nursing team monitored compliance with the cleaning contract and carried out spot checks of the premises.

The medics oversaw clinical waste. Clinical waste was secured, labelled, and stored safely in containers outside of the building. The contract provided for clinical waste to be collected every 2 weeks. A clinical waste register was maintained and consignment notes were up-to-date. The last annual healthcare waste audit was undertaken in August 2023.

Risks to patients

The doctors reported sufficient staffing levels to meet the needs of the patient population. The recent change to how ambulance response was staffed meant 4 paramedics moved from primarily administrative roles in the health centre to coordinating ambulance response shifts. The change resulted in more doctor availability as the duty doctor was no longer covering ambulance response. Although a duty doctor provided 24-hours a day 7 days a week, they were now called out less frequently.

The medics team was established for 22 staff. At the time of the inspection, there were 15 medics in post. This meant the training team established for 4 medics had just 1 medic in the team. With providing both 24-hour a day ambulance response, 24-hour airfield crash cover and routine practice duties, such as coordinating Aeromedical Evacuation (transfer of patients to and from the UK primarily for access to secondary care), medics reported they had insufficient time for other core duties within the health centre. These roles included the management of stores and clinical waste. Medics recognised there was a risk these core areas may not receive the level of attention they require. Despite this, the medics we spoke with said they did not work excessive hours. The practice had submitted a request for an uplift of 4 medics.

The nurses reported sufficient staffing levels to meet the needs of the patient population. We were advised they were not usually required to work additional hours unless it was an urgent need, such as a short notice deployment of a unit. The nurses did not work out-of-hours (OOH) or undertake remote triage. OOH triage was provided by the duty medic in liaison with the duty doctor who was available by telephone every day 24-hours a day.

The military OC PCRF (lead physiotherapist) post was vacant and was covered by the Band 6 physiotherapist which meant they were working 3 clinical days a week. The locum Band 7 physiotherapist should have been working 3 clinical days but was working full time clinically to cover the case load. Despite this, PCRF said there was sufficient staff to meet key performance indicators.

Records confirmed the medical emergency kit was checked at least 4 times a month or if the emergency trolley had been opened/used. We checked all items and they were in-date. The oxygen cylinder was full and in-date. Appropriate signage to indicate the presence of dangerous chemicals/substances was displayed on the doors where medical gases were stored. The external gas store was clean and tidy and had the appropriate no smoking sign displayed. A 'GlucoRx Meter was held on the trolley instead of the 'CardioChek Plus' as required in accordance with the 2022 Defence Information Notice (DIN04-147). The 'CardioChek Plus' was found unopened in the dispensary. Clinical staff were due to complete training in using the CardioChek Plus Test system.

Staff had difficulty opening the compartment containing the emergency medicines in the emergency trolley when we were checking it. They said this had not happened before. After the inspection, we were sent a video showing the trolley being opened and also a photograph of the notice on the trolley explaining how to operate it correctly. The practice manager promptly circulated an email to staff asking each to practice opening the trolley and to confirm they had done so. It was an older red hospital-style trolley and we considered there was a risk opening the trolley which could delay access to emergency medicines in the event of an actual medical emergency. We discussed whether it could be replaced with a more modern version.

The staff team was up-to-date with training in emergency procedures, including basic life support (BLS) and the use of an automated external defibrillator. Staff delivering BLS training had completed intermediate life support training. The medics were trained in paediatric BLS as they were involved in the 24-hour a day ambulance response to the Western Sovereign Base Area. We were advised that the medics had started to book onto a paediatric intermediate life support course in the UK.

Frequently led by the paramedics team, practice-based scenario training was undertaken several times a week. Recent examples included responding to the deteriorating patient, managing a patient with low blood sugar and managing a potential spinal injury. Sepsis training was held in September 2023 and 21 staff attended. One of the doctors provided staff with training regarding 'sepsis markers for children'. Staff were working through the recently introduced DPHC mandated heat injury training. They had also completed the required Station heat illness prevention training. Furthermore, 17 staff attended a heat illness training session at the practice in July 2023. The practice team, including the PCRF, recently received heat prevention training from the Institute of Naval Medicine.

Information to deliver safe care and treatment

Staff indicated there were regular occasions when Wi-Fi was not accessible. This usually resolved very quickly and did not pose a significant risk to continuity of patient care. We witnessed this happening during the inspection. As a failsafe, clinic lists were printed each day so the practice knew which patients were due to attend in the event DMICP was not accessible. Clinicians could also access patient records via DMICP Fixed (patient

electronic record used in UK Defence services) but cannot dispense medicines in this system. Therefore the practice only saw patients with an urgent need during this time or would divert patients to Episkopi Medical Centre. Paper forms were available for use during an outage, which were later scanned onto the system. It is noteworthy that each medical centre on the island had its own individual DMICP Deployed server so clinical teams were unable to see the clinical records of patients from another practice.

PCRF staff reported a DMICP outage in June 2023 that resulted in the department closing temporarily. DMICP Deployed was identified as an issue in terms of communication with the UK. In addition, we were advised this caused issues with communication across the island and also with the Regional Rehabilitation Unit and the Defence Medical Rehabilitation Unit. Efforts were being made to ensure that DMICP fixed was integrated with the other Western Sovereign Based Area medical centres to facilitate closer working and ultimately a shared on call rota.

DMICP permissions were set correctly to enable both physiotherapists and the ERI to see the same medical record. From a safety perspective, this meant the ERI, who predominantly worked alone in the rehabilitation suite, could view a patient's current health record.

Seven sets of family/civilian clinical records were awaiting clinical summarisation at the time of the inspection. There was a backlog of 3-yearly summaries for the records of service personnel and this was identified in the practice development plan. The actions involved doctors reviewing 10 records each week until the backlog was cleared, the administrative summary of records completed by the medics and the nursing team to review records for patient recalls.

We reviewed a wide range of DMICP records. Overall, we found record keeping was of a consistently good standard. However, the physiotherapists' clinical records were not always sufficiently detailed and clinical coding was not accurate. There was a plan in place to carry out an audit of the physiotherapists record keeping.

Arrangements were established for the regular peer review/auditing of clinical record keeping for all clinical staff groups. For example, nurses' record keeping was reviewed in June 2023 and medics record keeping in August 2023. The duty doctor reviewed the consultation notes of the duty medic and highlighted learning points. Findings from peer review was used to make improvements. For example, a theme identified from a PCRF peer review was that local pathways for the management of acute musculoskeletal injuries lacked clarity. In response, the team developed local guidance that took account of both the best practice guidelines and differences in management due to the nature of local hospital support.

A dedicated administrative team managed the referrals to Cypriot secondary care services, including physiotherapy referrals to the American Medical Centre (AMC). A referrals flow chart was in place for doctors and the administrative referral team so all were clear of the various referral pathways. The referral team outlined a comprehensive system to monitor the throughput and status of referrals. Colour coding was used to indicate the different stages of referral, including urgent referrals. Staff confirmed the patient usually secured a same day appointment if the referral was urgent. The Gov.UK Notify text system was used to notify patients of their appointment and a further text sent and a telephone call to the patient if needed. The dedicated administrator for the PCRF monitored the referrals made to the Regional Rehabilitation Unit Halton.

The medics coordinated referrals to secondary care services in the UK. The process was heavily administrative as it involved the use of the Aeromedical Evacuation (AE) or civilian airlines for the patient to return to the UK. The NHS e-Referral Service (e-RS) was used so the patient could choose the hospital they went to. The hospital liaised directly with the patient who could choose the date and time of their appointment. Every 2 weeks the medic checked the status of referrals and informed the doctors. The Digital Aeromed Referral Platform (referred to as DARP) was used to initiate and monitor AE. There were effective lines of communication in place with the AE team based in the UK. A total of 17 AEs had taken place in September 2023 and all had gone well without undue delays.

A process was established for the management of samples. Samples were sent Monday to Friday to AMC. Results were returned by email, scanned to DMICP and tasked to the requesting clinician. A member of the administrative team ensured results were obtained and informed the doctors and nursing team if any results were outstanding that required follow-up. Patients were informed of normal results by text. If the results were abnormal, the patient was invited to call to the practice for their results.

Safe and appropriate use of medicines

One of the doctors was the lead for medicines management and a pharmacy technician was the deputy lead. The pharmacy technicians were responsible for the day-to-day management of the dispensary and this was reflected in their terms of reference (ToR). The ToRs were reviewed in 2022 and were due a further review given the change of SMO.

A local working practice protocol was in place for access to the dispensary and controlled drugs (medicines with a potential for misuse) cabinet. Access was recorded in the working day book and the tag number holding the keys was recorded in the day occurrence book.

A bound book held in the dispensary was used to record the receipt and supply of the FMed296 prescription forms. Forms received were stored in the dispensary and the serial numbers of the first and last FMed296 were documented in the bound book. We observed that FMed296 prescriptions were issued by serial number and clinicians had signed and dated the receipt of prescriptions. We noted that the FMed296 log had yet to be updated in line with the guidance circulated to practices by the Regional Pharmacist Overseas.

Patient Group Directions (PGD), which authorise nurses to administer medicines, were signed off using the Annex E form from the JSP 950 9-4-2. Nurses used PGDs for immunisations and primary care treatments. A review of 3 patient consultations showed the PGD template was being used. From discussion, the nurses were familiar with the JSP 950 9-4-2 and were aware of the importance of referring to the PGD when immunising or supplying medicines through a PGD. A PGD audit had been completed in August 2023 by a pharmacy technician who was independent of the PGD user and the findings from the audit had been shared with the nursing team. Patient Specific Directions were not used and there were no non-medical prescribers at the practice.

There was a cupboard holding over-labelled medicines for the supply of PGD medicines. On the day of the inspection, there was a box of over-labelled co-codamol (medicine for pain) that had a patient name on the box. The name had been crossed out and the box placed back in the cupboard. If a patient name is written on an over-labelled medicine and the decision is made that the medicine is not going to be supplied to the patient, the over-

labelled medicine must be returned to the dispensary and not placed back in the out-of-hours (OOH) cupboard.

A stock check of 4 medicines from the OOH cupboard found discrepancies with 3 items. The stock discrepancies were co-codamol 30/500mg, amoxicillin 500mg capsules (antibiotic) and salbutamol inhaler (for asthma and breathing problems). Although a legal requirement, we found more than 10 boxes of over-labelled medicines had no medical facility address on the box. This was discussed with the pharmacy technicians and the address labels were added during the inspection.

Staff could not locate a local working practice protocol for the management of information about changes to a patient's medication OOH or by secondary care. However, they outlined a detailed process for the management of secondary care prescription requests with an audit trail to support the process. All written communication from OOH or secondary care was handed to reception. If the patient deemed the request urgent and needed a prescription, they were booked into the duty doctor clinic and the paperwork handed to the doctor. This was witnessed on the day of the inspection. If the request was not urgent, then the paperwork was passed to patient services who scanned the paperwork and tasked the doctor to action.

A comprehensive process was in place for the requesting and issuing of repeat medication, including a clear audit trail for the request of repeat medication. The pharmacy technicians were aware when requests should be tasked to a doctor. They only re-issued repeat prescriptions if the patient's review date was in-date and there were available repeat counts on the prescribing record. The process for handing out prescriptions to patients was discussed and witnessed during the inspection. It was in-line with the DPHC SOP.

We carried out a spot check of the dispensed repeat prescriptions and found all had been dispensed within 8 weeks. This indicated pharmacy technicians were effectively informing patients that their prescriptions were ready for collection and were efficiently returning uncollected medicines to stock if they are not collected within 8 weeks.

From discussion with clinicians and a review of patient records, we were assured that patients' medicines were appropriately reviewed, including treatment and clinical medicine reviews. All entries had been clinically coded.

The dispensary held appropriate medicine warning cards. Evidence was seen of detailed medication counselling when the pharmacy technicians handed prescriptions to patients. Patients were informed that an information leaflet was in the medicine's container.

Well defined processes were in place for the ordering and receipt of vaccines. All vaccines were in-date and were routinely rotated in the fridge. There was sufficient space around the vaccine packages for air to circulate. The temperature of the fridges was monitored twice a day and the external thermometers were in-date. We checked the stock of 5 different vaccines and they correlated with the DMICP record.

Medicines stock was effectively managed as the medicines with the shortest time expiry were placed at the front of the shelf. Time expiry reports were being run a month in advance and stock due to expire within the month was separated from the main stock to minimise the risk errors. All prescriptions were signed before they were dispensed by the pharmacy technicians.

We carried out a spot check of prescription only medicines and identified incorrect stock levels for 2 medicines. A stock check of the Medics Issuing Protocols (referred to as MIPs) cupboard showed discrepancies for co-codamol 8/500mg, ibuprofen 400mg and paracetamol 500mg.

Controlled and accountable medicines were kept in the dispensary in a controlled drug (CD) cabinet. The CD cabinet was not compliant with the Misuse of Drugs (Safe Custody) 1973 Regulations. This was risk assessed as being a low risk as the station was a secure base. A spot check of physical stock, DMICP and controlled medicines documentation (BMed12) identified no errors in the accounting of controlled and accountable medicines. Documentation in the BMed12 was clear and legible and was in accordance with JSP 950 Part 1 Lft 9-2-1 annex B. The specimen signature log in the BMed12 had been completed accurately by all those involved in the accounting of these medicines.

Internal monthly and external quarterly checks were being completed in line with the JSP 950 9-2-1 for all controlled and accountable medicines held as dispensary stock. An annual CD audit had been completed and an action plan developed. The annual self-declaration had been completed.

The CD cabinet keys were kept separate from the dispensary keys in a key safe in the dispensary. A log was maintained of when the CD cabinet keys were accessed. A process was in place for access to the CD cabinet OOH.

A review of the most recent destruction certificate confirmed that controlled and accountable medicines were being destroyed in accordance with the JSP 950 9-2-1 for the medicines held on dispensary stock.

It was evident that the high risk medicines (HRM) register supported the safe and comprehensive management of patients prescribed HRMs. Appropriate HRM and shared care alerts were identified on the patient's DMICP record. Required and timely blood monitoring had been undertaken. The pharmacy technicians ran the monthly DMICP HRM searches and shared the searches with the clinicians. An HRM monitoring audit had been completed by the pharmacy technician.

DMICP searches were carried out to identify any women of child-bearing age prescribed valproate (medicine to treat epilepsy and bipolar disorder). The most recent search was undertaken in October 2023. The pharmacy technicians were aware of the recent changes in that valproate must be dispensed as a full pack. They had access to patient information leaflets as part of the pregnancy prevention programme.

One of the doctors carried out an antimicrobial audit in August 2023.

Track record on safety

A designated health and safety lead and deputy for the practice were identified. Effective arrangements were in place to ensure the safety of the premises and equipment.

A legionella risk assessment of the building was completed in June 2023. Water temperature checks were regularly undertaken with the most recent in September 2023. An electrical check was undertaken in April 2023. There was no piped gas to the building. The building has been assessed by the Defence Infrastructure Organisation and graded as green on the seismic vulnerability map, meaning it was a low risk for earthquake activity.

The equipment manager was responsible for monitoring and ensuring the maintenance of equipment. An equipment assessment (referred to as a LEA) was undertaken in June 2023 and no significant issues had been identified. Portable electrical appliances had been checked in December 2022. Overseen by the ERI, a contract was in place for the maintenance of sports equipment.

Air conditioning was installed in the rehabilitation suite and gym staff carried out Wet Bulb Globe Temperature checks to indicate the likelihood of heat stress.

The building fire risk assessment was undertaken in July 2020. Firefighting equipment tests were current. Staff were up-to-date with fire safety training and were aware of the evacuation plan.

The SMO was the designated lead for risk management. The Warrant Officer was the deputy lead and had completed the Institution of Occupational Safety and Health course. A register of up-to-date risk assessments covering all aspects of patient/staff safety was in place including risks for the PCRF, lifting/handling, lone working and stress in the workplace. Control of Substances Hazardous to Health (COSHH) risk assessments were in place and COSHH products were stored appropriately.

As part of the Practice Development Plan, the leadership team was in the process of developing a new risk register to include the ‘4 T’s process’ (transfer, tolerate, treat, terminate). Alongside this, risk pathways were being clarified to ensure transferred risks were accepted and monitored. Risk was discussed at the healthcare governance meetings.

An integrated alarm system was in place for the medical centre and PCRF. Staff tested the alarm each month and recorded the tests on the 373 form (equipment check form). The same system was not in place for the ERI working in the rehabilitation suite. However, a lone working risk assessment was in place. The risk was mitigated by the ERI always carrying a phone to call for assistance if required or to call 112 in an emergency situation.

Lessons learned and improvements made

The Senior Nursing Officer (SNO) was the lead for the management of significant events. With the exception of the locum physiotherapist, all staff had access to the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events and incidents. After the inspection, the practice manager confirmed the locum had been given a log-in to access the system. An ASER register was maintained. The SNO reviewed the ASER system each week. However, staff informed the SNO when an ASER was submitted to ensure a timely action was taken. A trend analysis was undertaken quarterly.

A whole team approach was applied to the review of incidents and significant events. A monthly ASER meeting was held at which actions and lessons learned were agreed and recorded on the ASER log. Significant events were also discussed at the full team practice meetings. From interviews with staff and evidence provided, it was clear there was a strong culture of reporting and analysing incidents with a view to making improvements. All staff we spoke provided varied examples of incidents reported through the ASER system including the action taken and improvements made. The ASER trend analysis undertaken

identified that secondary care provision was the main source of incidents reported. Lessons learnt and trends were shared widely with BFC.

The practice identified that sometimes the scheduled ASER meeting was too far in the future to discuss a significant event which may have just happened. To capture details in a timely way and enable prompt lessons learnt, the practice introduced the 'SWARM' template. This supported with quickly identifying whether immediate action or change was needed following the significant event/incident or whether it could wait until the ASER meeting and a full root cause analysis.

An effective process was in place for the management and action of Medicines and Healthcare products Regulatory Agency (MHRA) and National Patient Safety alerts. The MHRA alert register was current and a system was in place to ensure the practice received, disseminated, and actioned all alerts and information relevant to the practice. Two alerts from June 2023 were missing from the register but evidence was seen that the information had been disseminated to the practice. The register was updated on the day of the inspection. Practice meeting minutes showed alerts were discussed with a link to the MHRA register embedded in the minutes.

Are services effective?

We rated the practice as good for providing effective services.

Effective needs assessment, care and treatment

Processes were in place to support staff to keep up-to-date with clinical developments including National Institute for Health and Care Excellence (NICE) guidance, clinical pathways, legislation and standards. New or updated guidance was reviewed at the clinical meetings. One of the civilian medical practitioners (CMP) had worked at the practice for over 20 years so provided continuity given their detailed knowledge of the practice, population health care needs, specific issues related to Cypriot health care and issues in relation to British Forces Cyprus (BFC) primary health care delivery. Through review of current literature, the CMP provided regular clinical updates for clinicians.

Multi-disciplinary team meetings for clinical staff were held weekly to discuss patients, including those with complex needs. In addition, physiotherapists had direct line access for advice to a UK-based Defence consultant advisor or through the Pando app via the duty doctor. The Pando app is an evidence-based encrypted instant messaging system used in NHS and Defence services to securely share patient information.

The primary care rehabilitation facility (PCRF) had the necessary equipment and space needed to deliver an effective service. Patients were assessed by the physiotherapist and referred to exercise rehabilitation instructor (ERI) where appropriate.

Physiotherapists referred to Defence Rehabilitation best practice guidelines to ensure best practice was followed where possible. Occasionally, different stages of care unique to the Cypriot system were followed and local guidelines were used to support this deviation. Physiotherapists described appropriate use of objective outcome measures such as the single leg hop and double leg hop. However, the MSK-HQ was not used and we highlighted to the team that this needs to be completed as it is a mandatory patient recorded outcome measure. Furthermore, the Rehab Menu Template was not always used and, when used, was not always used appropriately.

Physiotherapists used Rehab Guru (software for rehabilitation exercise therapy), which provided patients with injury prevention information and templates. The Rehab Guru number was recorded in the patient's record and the exercises were outlined. Patients were encouraged to download the Rehab Guru app. The ERI used a graded programme of rehabilitation delivery. Physiotherapists indicated that the ERI effectively managed their own caseload leading on rehabilitation and physical training reconditioning, taking patients all the way from injury to military fitness standards.

Physiotherapists worked in a holistic way taking account of the patient's lifestyle and wellbeing underpinned by the principle of 'Make Every Contact Count'. This included discussions around smoking, drugs, alcohol, weight management, stress and sleep. Physiotherapists could refer patients to SSAFA for other support pathways.

Step 1 of the mental health intervention programme was undertaken at the practice. For step 2 of the programme, patients were referred to the Department of Community Mental Health (DCMH). In addition, patients had access to support from multiple sources including

a wide-range of information leaflets and access to welfare support, which they could utilise while awaiting referral to the DCMH. A DMICP search identified 16 patients were being treated for depression. Our review of clinical records for patients with a mental health need showed appropriate evidence-based management including assessment, diagnosis, clinical coding, prescribing and monitoring.

The practice provided a limited service to a small detention centre in the catchment area for Sovereign Base Area detainees (less than 10 detainees). Provision involved 'fitness to detain' medicals and occasional primary health care provision. This service was provided to patients at the practice.

Monitoring care and treatment

The Senior Nursing Officer (SNO) and one of the doctors were 'the champions' for chronic disease. They worked closely together to ensure continuity and consistency. Each of the nurses had a responsibility for monitoring patients who had a chronic disease. Monthly DMICP searches were carried out to ensure the chronic disease register was up-to-date and a detailed process was in place to recall patients.

Nine patients were identified as having diabetes and all were managed appropriately. Patients at risk of developing diabetes were identified through over 40s health checks, the pre-diabetes/gestational register and opportunistically. Forty-seven patients were identified as having high blood pressure and 43 had a blood pressure check within the required timeframe. Twenty-six patients had a blood pressure reading of 150/90 or less which is an indicator of positive blood pressure control.

Seventy-two patients were diagnosed with asthma and 39 had an asthma review in the last 12 months. Five were new patients to the practice so had only recently been identified on the monthly search. The SNO advised that often patients, particularly new patients, had been coded incorrectly and codes were not changed until the patient was reviewed. In addition, some had 'dormant' asthma. The SNO confirmed all patients had been recalled with many on their second and third recall. If the patient failed to respond following 3 recalls, the doctor with the lead for chronic conditions then made contact with them. Where appropriate, the doctor provided shorter courses of repeat medications in an effort to persuade the patient to attend. Alerts were also added to the patient's record. The wide range of clinical records we reviewed for chronic conditions showed patients were recalled and managed in an effective way.

Audiology statistics showed 66% of patients had received an audiometric assessment within the last 2 years. Our review of patient records showed Joint Medical Employment Standards (referred to as JMES) were appropriately managed.

The CMP was the lead for quality improvement activity/audit and the deputy Senior Medical Officer deputised. An audit calendar was established for 2023, which captured the routine monthly audits and additional audits planned for each month. The lead monitored the audit programme and alerted colleagues when audits were due to be carried out.

The audits undertaken clearly demonstrated that quality improvement was embedded in the practice. Staff actively engaged with audit activity and the register indicated a balanced range of data searches, mandated audits and patient population-based clinical audits. The range of clinical audits included those related to chronic conditions; thyroid; breast

screening; cytology screening; management of diabetes; bowel screening; epilepsy; depression; minor surgery and osteoporosis. The selection of audits we reviewed were of a good standard and were in accordance with the DPHC recommended audit structure. There were numerous examples of repeat audits. Although there was evidence of a small number of PCRF-led audits identified on the audit register, there was scope for further integration of the PCRF in this area. Minutes indicated the outcome of audits were shared with the team at healthcare governance meetings.

Effective staffing

All staff who joined the practice were required to complete an induction programme that combined the DPHC mandated induction and local induction specific to Akrotiri. It was under review at the time of the inspection. We spoke with members of staff who recently joined the practice and they confirmed the induction process was comprehensive. One of the staff confirmed they had the opportunity to shadow for as long as they needed before being required to undertake any tasks that they did not feel completely confident in.

One of the medics monitored the status of mandatory training for the team. The training spreadsheet showed high levels of compliance across all staff groups. Collectively, clinicians had a wide-range of qualifications and experience to meet the needs of the patient population. All doctors had training and experience in aviation medicine. Some of the doctors were qualified in the delivery of pre-hospital emergency care and others had specialist skills, such as combat medicine/boxing and diving medicals. In addition some of the doctors were qualified to undertake minor surgery and contraceptive implants.

Besides a recently appointed nurse, the nurses had completed the basic practice nursing courses including taking blood, vaccinations, ear irrigation, travel health and vaccinations. Some of the nurses had completed additional courses, such as smear taking, menopause and asthma. Funding had been secured for additional training in ‘recognising the sick child’ and triage for reception and nursing staff. Three of the nurses at the practice had completed spirometry (lung function test) training. The doctors carried out the interpretation element of spirometry.

The nurses did not have specific qualifications in paediatric nursing but many had experience of assessing and treating children. During working hours both nurses and medics triaged children. A local working policy (LWP) was in place outlining the arrangements for the telephone triaging of adults and children. The aim of the LWP was to provide guidance in a telephone triage assessment that aligned with NHS guidelines. The LWP outlined ‘red flags’ for a wide-range of conditions with a traffic light system for the action to take. For example, 112 was contacted for urgent symptoms including head injuries, burns, active bleeding, loss of consciousness, convulsions, early onset of labour, and stroke symptoms. The nurses and medics also carried out face-to-face triage and said this mainly involved taking a history and observations. Medics advised that children mostly presented with insect bites, bites from stray cats and minor injuries from falls. NICE information was clearly displayed in clinical rooms including the sepsis risk stratification for children aged 5 to 11 and the traffic light system for identifying risk of serious illness in children under 5.

For the majority of children, the nurse or medic involved the duty doctor particularly as a prescription was often required. Nurses advised us they were comfortable with assessing

children as the duty doctor was accessible and responsive to any concerns identified through triage. Nurses and medics referred children under the age of 2 to the duty doctor. The SMO promoted the involvement of nurses and medics in decision making for their experience and learning. The Band 6 physiotherapist recently attended paediatric training.

The practice introduced a standardised assessment process for medics as an initiative to enhance the confidence of medics, particularly if they were not used to taking a clinical history. This process providing structure and ensured vital information was not missed especially when handing over care to other clinicians or facilities.

In-service training (IST) was delivered each week and supported staff with continuing professional development (CPD). Clinicians were responsible for maintaining their own CPD portfolio. Appraisal and revalidation were in-date for all clinical staff. Staff described good access to clinical supervision and said support was available from both nursing and medical colleagues. A practice nurses' meeting was held each month and clinical supervision sessions for nurses took place 6 weekly. A collaborative approach was taken to training for nurses that included joint training days with the nurses at Episkopi and Dhekelia medical centres. The PCRF team engaged with regional IST with different members of the PCRF presenting a topic on a rotational basis.

The practice had General Duties Medical Officer supervisors. Two doctors were pursuing General Practice Education Committee accreditation in an effort to return the practice to a training practice. There were shared study days between the practice and Episkopi Medical Centre.

Coordinating care and treatment

Discussions with staff indicated the practice had well developed links with station commanders and the welfare team. In addition, the team had good relationships with the co-located DCMH team and SSAFA. We spoke with a member of the welfare team who described a pro-active response from the practice if they were concerned about a patient or they indicated the patient urgent need to see a doctor.

Service personnel seldom left the military direct from Cyprus. More often they returned to a UK service and subsequently were discharged from there.

Helping patients to live healthier lives

Clinical records we reviewed showed that supporting patients with healthy lifestyle options was routine to consultations where appropriate.

A lead was identified for health promotion. Health and lifestyle information was available throughout the patient areas of the building. Information displays were based on the specific needs of the patient population and risks associated with living on the island, such as mosquito bites, smoking cessation, mental health, cervical screening, menopause, asthma and responding to an earthquake.

The practice identified that health promotion assets across British Forces Cyprus were lacking. With additional funding secured, the practice started a 'health promotion library'.

Resources purchased include smoking/vape cessation displays, sugar displays, drink displays, skin cancer discs, breast and testicle displays. These have been used for patient education, at health fairs and sometimes for other population groups such as school children. The practice loans these resources out across island for wider population benefit.

Based at the practice 2 days a week, a sexual health nurse from the Military Advice and Sexual Health/HIV (MASSH) team had been posted to the island to provide sexual health services. They were appropriately qualified for the role having completed the Faculty of Sexual Health training and provided a level 2 sexual health service for patients.

Although the nurses could provide a level 1 sexual health service, patients were usually referred to the MASSH sexual health nurse. The nursing team described how the sexual health nurse went above and beyond their role to provide a comprehensive service. The MASSH nurse was actively involved with sexual health promotion, including to the school nurse and the setting up of a youth drop in clinic. They briefed every regiment arriving on the island, talking about the risks associated with sexual health and how to access screening and support.

The MASHH nurse had the option to attend both practice and healthcare governance meetings and were also actively involved in quality improvement activity. A display at the practice provided patients with information about sexually transmitted infections and how to seek advice.

DMICP searches were undertaken each month in line with national screening programmes and eligible patients invited for screening. An audit (April 2022 - March 2023) showed 100% of females eligible had been invited and had received a mammogram. Figures at the time of the inspection showed 97% of eligible women had been screened. Rather than the NHS home test kit (referred to as FIT), bowel screening involved a faecal blood test (referred to as FOB) which was processed at the American Medical Centre. Patients were advised to request the gold standard FIT test when they returned to the UK.

Processes were in place to ensure patients were notified of their eligibility for cervical screening. Recalls were undertaken monthly covering a 3-month period if no response was received. Recalls were undertaken by letter, text and telephone. An audit completed in March 2023 identified 88% of eligible women had received a smear test. The audit indicated 4% of women recalled had not responded.

SSAFA oversaw the childhood immunisation programme. Using the ‘birth book’ (Redbook), SSAFA called and recalled children for vaccinations. The primary immunisation appointments for 2,3 and 4 month appointments were given to the family at the primary birth visit. One year vaccinations were given just after the child’s first birthday. Sovereign Base Area administration checked the birth book the month before, allocated an appointment on DMICP and sent an appointment to the parent. Similarly, for the pre-school boosters, the birth book was checked monthly before vaccinations were due and an appointment allocated. The parent of children missing an appointment were usually telephoned on the day to see if they could attend. Children who had not attended were offered the next available appointment. Staff said this manual system worked and was effective.

The following vaccination statistics were submitted by SSAFA and are island-wide for British Forces Cyprus.

- The percentage of children aged 1 who had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (i.e., 3 doses of DTaP/IPV/Hib/Hepatitis B) was 98%.
- The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection was 99%.
- The percentage of children aged 2 who had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e., received Hib/MenC booster) was 99%.
- The percentage of children aged 2 who had received immunisation for measles, mumps and rubella (one dose of MMR) was 99%.
- The percentage of children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) was 98%.

Vaccination statistics for service personnel:

- 94% of patients were in-date for vaccination against diphtheria.
- 94% of patients were in-date for vaccination against polio.
- 100% of patients were in-date for vaccination against hepatitis B.
- 98% of patients were in-date for vaccination against hepatitis A.
- 94% of patients were in-date for vaccination against tetanus.
- 100% of patients were in-date for vaccination against mumps, measles, rubella.
- 98% of patients were in-date for vaccination against meningitis.

One of the nurses monitored the vaccination status of service personnel by undertaking a monthly DMICP search. Anyone due a vaccination was contacted by text and asked to make an appointment. Repeat texts were sent to non-responders. Ultimately, service personnel could not be signed off to deploy if their vaccinations were not up-to-date.

Consent to care and treatment

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Implied consent was mainly used. Written consent was taken for minor surgery and contraceptive implants. The clinical records we looked at showed consent was obtained from patients where required. Although the physiotherapist documented consent for acupuncture on DMICP, we highlighted that an information leaflet regarding acupuncture should be routinely given to the patient. Consent was monitored as part of the record keeping peer review/audits.

Although clinicians understood the Mental Capacity Act (2005) and how it would apply to the patient population group, there were no examples of when a mental capacity assessment had been required. All doctors interviewed were aware of both Gillick competence (young people under 16 with capacity to make a decision) and Fraser guidelines (advice/treatment focused on a young person’s sexual health).

Are services caring?

We rated the practice as good for providing caring services.

Kindness, respect and compassion

To ensure patient's views contributed to the inspection, we offered patients various opportunities to provide feedback on the service. Patient views were shared through CQC feedback cards completed by patients prior to the inspection, by email and through interviews with patients on the day of the inspection. Parents also provided feedback about the care their children received. Overall, feedback about staff at the practice indicated patients were treated with kindness and respect.

Patients expressed mixed views about the attitude and compassion of staff in secondary care services. We passed these concerns to the Senior Medical Officer for follow up. We received confirmation after the inspection that the concerns were being addressed.

We were provided with various examples of when practice staff had gone 'the extra mile' to support patients. For example, the practice loaned a chair to the patient in pain as they found a chair in the medical centre was comfortable and helped eased their pain. In addition, a patient registered at Dhekelia Medical Centre asked to be seen at Akrotiri Health Centre for convenience. The practice accommodated this request and also booked a follow-up appointment at Dhekelia Medical Centre without the patient requesting this. The patient provided feedback to the practice for their kindness and support.

A further example related to a patient with a complex musculoskeletal injury who had been referred to the American Medical Centre (AMC). As the family were dissatisfied with the patient's management at AMC, one of the physiotherapists made additional enquiries about the patient's management plan with experts in the UK via the Defence Consultant Advisor Network. This resulted in reassurance for the family.

The practice had strong links with the welfare service, SSAFA and the British Forces Cyprus social worker. Details about how service personnel and families could access the HIVE Information Centre and SSAFA was available, including through the practice's social media platform.

Involvement in decisions about care and treatment

Our review of clinical records and patient feedback about the practice indicated patients were actively involved in the planning of their treatment and care, including where they were referred to for secondary care. Patients told us they could select their hospital of choice when referred back to the UK for secondary care.

Patients with a caring responsibility were usually identified when they registered with the practice. A clinical code was applied to their records so they were identifiable as a carer when they contacted the practice for an appointment. A member of staff was identified as the carers lead and the practice referred to the Defence Primary Health Care (DPHC) standard operating procedure for carers. Information for carers was displayed in the

waiting area, included in the practice information leaflet and on various social media platforms for the practice. Carers had access to the wide-range of welfare support services provided by British Forces Cyprus. The most recent DMICP search (6 Oct 2023) identified 6 registered patients with caring responsibilities.

An interpretation service was available for patients who did not have English as a first language. Staff advised us it was regularly used. In urgent situations, and with patient consent, Cypriot employed staff provided translation.

Privacy and dignity

The waiting area was large and open-plan with the seating area set back from the reception. This arrangement along with a radio for background noise minimised patient conversations being overheard at reception. A notice was displayed advising patients a quiet room was available, including for breast feeding, needing space from others or to speak with reception staff in private.

Consultations took place in clinic rooms with the doors closed. Privacy curtains were used when patients were being examined. Telephone consultations were undertaken using headsets to maximise patient confidentiality.

There was a good mix of male and female staff within the practice so patients could request to see a clinician of their preferred gender. If a patient requested a female exercise rehabilitation instructor (ERI) then a physiotherapist would undertake the rehabilitation elements with advice from the ERI.

All staff were up-to-date with the mandated Defence Information Management Passport (DIMP). The DIMP took account of the Caldicott Principles to ensure patient information was kept confidential and used appropriately. The 8 Caldicott Principles were displayed throughout the practice.

Are services responsive to people's needs?

We rated the practice as requires improvement for providing responsive services.

Responding to and meeting people's needs

Two main themes emerged from patient feedback provided as part of the inspection. Firstly, patients referred to both Cypriot and UK secondary health care (SHC) services expressed a dissatisfaction centred around communication between the clinicians at the practice and SHC consultants, and with the patient. With patient consent, we checked the records for patients who raised concerns. The records clearly catalogued engagement between the clinician and SHC consultant. However, there was scope for improving the timeliness of communication with the patient and clarity around who should communicate with the patient and in what circumstances; the SHC consultant or the practice clinician. On occasions, patients said they were the 'go between' communicator between both parties indicating this was not appropriate and caused unnecessary stress. Secondly, some patients highlighted that medicines prescribed by SHC were not medicines held at the practice, which meant they were prescribed an alternative medicine. Again with patients consent, we passed these concerns to the practice to follow-up. We received confirmation after the inspection that the concerns were being addressed.

To gain a balanced view, we discussed the themes raised by patients with the doctors. We were advised that doctors have the responsibility to ensure the care being provided by Cypriot SHC equates with what patients would expect of the NHS. As part of this, doctors were asked to approve some recommended procedures indicated by SHC consultants before they proceeded. Doctors expressed concern about this. Firstly, it was a unique position for a primary care doctor to ask for an opinion from a specialist and then decide if on the appropriateness of that advice. To aid with approving the decision, doctors could reach back to the Defence Clinical Advisor in the UK. The doctors indicated this was a cumbersome process and at risk to error. Furthermore, there was a likelihood this process could mean delayed and/or fragmented communication with the patient.

In addition, when a Cypriot consultant prescribed a medication or treatment not used in the UK, practice doctors had to decide on an alternative used by the NHS as the dispensary only stocked medicine routinely used in the UK. This was possibly another source of friction for patients who may have perceived they were not getting the treatment the consultant had advised.

Access to services ordinarily available in UK was limited so Akrotiri Health Centre was providing more than routine primary care to ensure patients had access to a full range of services, including minor injuries and a GP out-of-hours service.

The needs of the patient population was considered when configuring service provision. For example, clinics for teachers and school children were available before and after school hours. Cytology screening appointments were facilitated when children were at school. Pharmacy opening hours had been revised to align with the doctors' clinic times. The physiotherapists team facilitated a long clinic on a Monday 06:45-17:00 hours to accommodate patients who could only attend in the afternoon. The practice identified the need for a menopause clinic, facilitated by one of the nurses who completed additional

training in women's health. Patients could book hour long slots for assessment and advice. The nurse referred to a doctor if needed.

Akrotiri is a flying station so the practice provided 24-hour access 7 days a week for aircrew, including prompt access to aviation advice.

To ensure continuity of physiotherapy, patients remained with the same physiotherapist throughout the duration of their episode of care.

In response to understand the increasing use of eConsult, the Senior Nursing Officer carried out an audit in May 2023. Key trends were identified from the audit and as result a quarterly electronic newsletter was developed using the Sway Microsoft Office app for sharing interactive information. We reviewed the autumn addition of the newsletter. This user-friendly newsletter covered a wide range of topics to support patients with understanding what the health centre provided and when and how to seek healthcare intervention. It included an electronic version of the patient information leaflet and any changes to clinical staffing at the practice. The newsletter captured a wide range of information about health, such as the different types of appointments required depending on the symptoms the patient was experiencing. Some of the information included related to lifestyle, mental health, Covid-19, flu vaccination eligibility, carrying out skin checks and services available to carers. Various links and quick response codes were embedded including a link to 'Healthier together', a nationally recognised website providing advice for parents, young people and pregnant woman. This newsletter was a good example of initiative taken to enhance the health literacy of the patient population.

An Equality Access Audit for the premises was completed in October 2022. The building was accessible, including automatic front doors, wider internal doors, an accessible patient toilet and a hearing loop.

Timely access to care and treatment

Patients who provided feedback indicated that overall it was easy to get an appointment to suit their needs.

A 'traffic light' process, including a flow chart and guidance, was used by the reception team to ensure patients making contact with the practice for the first time were directed to the most appropriate clinician/team. This process supported with streamlining the service and maximised patients being seen in a timely manner by the correct clinician. Furthermore, it aimed to prevent inappropriate clinic loading by prioritising individual need.

The practice operated daily in 3 parts - early morning clinic, late morning clinic and an afternoon clinic. Urgent and routine face-to-face appointments with either a doctor or a nurse could be accommodated on the same day if required. In addition to face-to-face consultations, telephone appointments and home visits with a doctor could be facilitated. During the week eConsult was regularly used for triage and to request repeat medications. Specialist medicals could be accommodated within 2 weeks.

The physiotherapists were not using the direct access physiotherapy (DAP) process at the time of the inspection. In accordance with the DAP standard operating procedure, Regional Headquarters were aware. We noted introducing DAP was an action identified on the Practice Development plan and we were provided with evidence to confirm the Senior

Medical Officer (SMO) was pro-actively pursuing setting it up in the absence of an OC physiotherapist.

An urgent referral with the physiotherapist could be accommodated within a day and routine/follow up appointments within 2 days. Both new and follow-up appointments with an exercise rehabilitation instructor were available on the day and access to a rehabilitation class was within 2 days. Aqua therapy was held weekly. A wide range of individual sessions were available for patients in the rehabilitation suite. In addition to referrals to the American Medical Centre, the Regional Rehabilitation Unit (RRU) Cosford provided a responsive peripatetic (visiting) podiatry clinic on the island. Similarly, RRU Halton provided a peripatetic Multidisciplinary Injury Assessment Clinic.

The practice was staffed by a paramedic, medic and duty doctor 24 hours 7 days a week for emergency medical cover to the airfield and Western Sovereign Base Area. Patients with an urgent medical need had access to this service out-of-hours.

Listening and learning from concerns and complaints

The practice manager was the lead for complaints with the Warrant Officer deputising. Although having oversight of all complaints, the SMO mainly provided input for complaints related to clinical care.

The complaints procedure was outlined in the practice information leaflet (PIL) including the contact details for the complaints manager. In addition, information about how to complain was available on the practice's social media platform and displayed in the practice, including how to complain about SHC. The PIL also included the email address to make a complaint about secondary health care (SHC) services (managed by HQ Med Branch). Forms to submit a written complaint were available in the waiting area. Patient complaints about SHC were processed by the practice in the first instance and then passed to HQ Med Branch. Despite the availability of information, the patients who raised concerns with us had not pursued their concerns through the formal complaints process. This would suggest that further work is needed to ensure patients fully understand the complaints process, including the different pathways for practice-related complaints and complaints about SHC.

With the recent changes to practice management, a comprehensive review of all complaints had been undertaken to ensure all active complaints were captured and were being addressed. Each complaint had a separate folder on SharePoint with the complaint register number used as the reference. Colour coding was utilised to indicate whether complaints were open or closed. At the time of the inspection, there were 16 open complaints; 11 of these related to patient experience of secondary care services. We discussed a recent complaint and it had been appropriately addressed in line with Defence Primary Healthcare policy and also to the satisfaction of the complainant. Complaints were discussed with the wider staff team at practice meetings.

Are services well-led?

We rated the practice as good for providing well-led services.

Vision and strategy

The practice worked to the Defence Primary Healthcare (DPHC) mission statement:

> "To provide and commission safe and effective healthcare which meets the needs of the patient and the Chain of Command in order to contribute to Fighting Power."

The vision for practice was defined as:

> "The leadership, management & governance ensures we provide high-quality care…that it encourages learning, innovation & a fair, open culture."

The leadership team was new with the Senior Medical Officer (SMO) and Warrant Officer taking up post in recent months. They recognised the practice's strengths, weaknesses, opportunities and threats and had a clear vision to optimise the safety, efficiency and effectiveness of the service. Achieving this vision was captured in the Practice Development Plan. We found the leadership team was clear about the changes that needed to be made to benefit the practice in the medium and longer term.

Succession planning was considered and involved liaison with the career managers to minimise key military management personnel not being deployed at the same time. Civilian medical practitioners, civilian nurses and civilian physiotherapists provided consistency in the clinical staff groups.

The medical centres on the island had been working to the OPAL ratings as defined by the DPHC Op Order published by Commander DPHC. This outlined the 12 DPHC priorities predicted for the year. The reason for the OPAL rating was to ensure patients and staff were safe. Akrotiri Health Centre was rated 'Amber'. The rating had not adversely impacted the provision and continuity of patient care.

A theme from patients who contributed to the inspection was a dissatisfaction with secondary health care (SHC) provision, not just with the American Medical Centre (AMC), the main SHC provider on the island but with other Cypriot providers and UK services. Communication from SHC providers and the interface with practice clinicians was the main concern raised by patients. This is an area that needs to be explored further so the patients' experience can be improved.

Contracts with Cypriot secondary care services were overseen by Med Branch at Headquarters British Forces Cyprus. Concern was raised about the lack of engagement with practice clinicians in the service design of Cypriot SHC, quality assurance of SHC provision and contract monitoring with the AMC. Doctors said they had not been informed of the outcome or had sight of quality assurance reports of AMC. In addition, doctors advised that changes to SHC service provision were not communicated to them. For example, the doctors were unaware AMC did not provide a service for children under 2 years. This only became apparent to them when the contract was in place.

To address environmental sustainability, the practice was making an effort to reducing the use of paper and printing through sharing information electronically. As an example, the

Primary Care Rehabilitation Facility (PCRF), provided patients with Rehab Guru plans via the app rather than paper copies.

Leadership, capacity and capability

We interviewed a wide range of staff throughout the inspection and all said leadership capacity was sufficient as heads of departments were visible with staff having prompt access to support and guidance if needed. They provided examples to demonstrate this support. In terms of capability, staff indicated they had confidence in how the leaders managed the practice. In particular, staff made reference to how well leaders invested in the staff team.

We found that the leadership team worked very well together to achieve the vision for the service. They demonstrated high levels of experience, capability and resourcefulness to provide a responsive and sustainable service for the patient population. The leadership team described responsive and timely support from the regional team.

Culture

A patient-centred focus was clearly evident from patient feedback about the practice and from discussions with staff. Staff understood the specific needs of the patient population and tailored the service to meet those needs.

We heard from staff that morale and communication between the departments had been in decline but was now improving under the leadership of the new SMO. One of the key areas identified on the Practice Development Plan was based on the '5 C's of change' – culture, communication, courage, conviction and compassion. Staff we spoke with indicated there was a high level of energy in the health centre as they were starting to see positive change. They said there was an open-door policy with everyone treated equally regardless of service background, rank or grade. A weekly 'tea and toast' session was held with each department taking turns to lead on this. Team building sessions were held once a month including activities, such as team walks and a water sports force development visit.

The practice meeting structure was inclusive and junior staff held their own meeting led by a medic who provided feed back to the leadership team. Staff were familiar with the whistleblowing policy and said they would have no hesitation in raising concerns about professional standards.

Processes were established to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The practice maintained a duty of candour log.

Governance arrangements

The Senior Nursing Officer was the lead for healthcare governance (HCG). There was a defined staff reporting structure in place. Staff were aware of their roles and responsibilities. Lead roles were shared across the practice team and included all departments. Although terms of reference were in place for main roles and subsequent lead roles, some needed further development, review and sign off. This was an action identified on the Practice Development Plan.

A wide range of formal and informal meetings were held to ensure effective communication and information sharing across the staff team. These included a 'daily huddle' to ensure the smooth running of the service each day, practice meetings and HCG meetings, which the whole team attended. Attendance at meetings supported a multi-disciplinary approach. The PCRF team was integral with the practice and attended all relevant meetings. The SSAFA team attended the weekly heads of department meetings. Both departmental and clinical meetings were held on a regular basis.

The HCG workbook was extensive and well referenced. All staff had access to the workbook as the main method to share governance information across a large practice. The HCG workbook is used in defence primary healthcare services as the overarching system to bring together a range of governance activities, including the risk register, medicine alerts, audit, health and safety and quality improvement.

Non-attendance for secondary care appointments at the AMC was closely monitored as there was a charge if the patient cancelled the appointment with less than 48 hours' notice. The practice submitted the non-attendance statistics to HQ each month.

Managing risks, issues and performance

As outlined in the Practice Development Plan, the leadership team was developing a new risk register with the aim to include the '4 T's process', a risk management structure routinely used across defence primary health care practices. The Warrant Officer was reviewing all risks in detail to ensure transferred risks had been accepted by the risk holder. An issues log was being developed as part of this process. Although some of the risk assessments were marginally out-of-date for review, they were relevant and current. The practice planned to review these.

Processes were in place to monitor national and local safety alerts, incidents, and complaints. This information was used to improve performance. The business continuity plan and major incident plan were reviewed in June 2022. Staff were aware of their role within the major incident plan and an exercise was scheduled to take place the end of November 2023.

The leadership team was familiar with the policy and processes for managing staff performance. Although not a concern that was indicated at the time of the inspection, they were familiar with the range of processes to manage performance including welfare support, re-training, appraisal and disciplinary processes.

Appropriate and accurate information

The DPHC electronic health assurance framework (referred to as HAF) was used to monitor performance. It is an internal quality assurance governance tool to assure standards of health care delivery within Defence healthcare. An Internal Assurance Review (IAR) of the practice was undertaken in November 2022. Safe and well-led received a grading of limited assurance with effective, caring and responsive graded as substantial assurance. The IAR was being used as a baseline to improve processes and services. The Management Action Plan (MAP) from the IAR had been uploaded to the HAF. At the time of the inspection, there were only 6 remaining actions. We were advised the outcome of this CQC inspection and the General Practice Education Committee review in February 2024 would be added to the MAP.

Arrangements were in place which were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

New patient feedback posters were displayed at the practice and the request for feedback was advertised on the practice's social media platform and via email to patients. Various options were available for patients to provide feedback on the service and these were explained in the quarterly patient newsletter. The newsletter outlined the importance of patient feedback and included a link to access the DPHC patient survey. There was a comments box for patients attending the PCRF. The comment forms submitted were reviewed regularly by PCRF staff.

The leadership team had removed the 'you said, we did' board as it was outdated. The plan was to reinstate this once meaningful patient feedback was submitted that the practice could act upon.

Practice staff attended the monthly Health and Wellbeing committee meeting each month where they engaged with key unit personnel and welfare staff.

Although an external staff survey was conducted between March and May 2023, the leadership team had not been given the results. We discussed whether it would be valuable to undertake a further staff survey given the change in leadership and pace of change made in recent months. This would give the leadership team an insight into the impact of change for individual staff and a collective view as to how the service is developing.

Continuous improvement and innovation

The audit and quality improvement registers clearly demonstrated that the practice continually sought to improve the service for patients. Although there was evidence of quality improvement activity, we identified two good practice initiatives which were not

included on the quality improvement register therefore it was unclear if they had been raised as quality improvement projects (QIP). These included the local best practice guidance developed by physiotherapists and the quarterly electronic patient newsletter. Raising QIPs and uploading them to the DPHC Healthcare Governance webpage showcases positive performance and also enables the sharing of good practice with other DPHC facilities.